Treat PTSD, Substance Abuse at the Same Time

BY BETSY BATES

A revolution is brewing in the treatment of patients with co-occurring posttraumatic stress disorder and substance use, inspired by a growing body of evidence that the disorders can be successfully addressed simultaneously.

An estimated half of returning veterans and a third of civilians with PTSD have co-occurring substance abuse, while up to 42% of people in treatment for addictions have a current diagnosis of PTSD. Yet, few programs traditionally addressed both issues simultaneously.

Patients presenting with PTSD were excluded from research studies and many treatment programs if they had an ongoing substance use problem.

Barriers blocked the route to dual treatment at substance abuse clinics as well, where clinicians were reticent to address, much less treat, PTSD.

"There's been a kind of historical trepidation to deal with PTSD when people are trying to get stabilized in a substance abuse program," said Mark P. McGovern, Ph.D., a psychologist who serves on the psychiatry faculty at Dartmouth Medical School, Hanover, N.H.

"The thought has been, you don't want to open Pandora's box and undermine the original goal of substance use stabilization," explained Dr. McGovern in a telephone interview. "But for many patients, Pandora's box was already open and the demons were out. They were suffering nightmares, flashbacks, [and] extreme anxiety, and until you dealt with those symptoms they were never going to stop using substances."

Dr. Thomas Kosten, professor of psychiatry at Baylor University, Houston, and research director of the VA Substance Use Disorders Quality Enhancement Research Initiative, described a similar epiphany that occurred in the PTSD treatment community, which traditionally had insisted that patients be clean and sober before beginning therapy.

"The new veterans with PTSD cannot be effectively treated with behavioral therapies like prolonged exposure unless their binge alcohol abuse is controlled," he said. "Otherwise any gains in therapy during the week will be lost in a weekend of binge drinking, and binge drinking occurs in half of these vets. This problem is too common to ignore."

Lisa Najavits, Ph.D., a psychologist and professor of psychiatry at Harvard Medical School, Boston, said the "big myth" that substance abuse and PTSD had to be treated sequentially persisted throughout much of the 20th century, even as a preponderance of evidence showed that severity of symptoms was higher and PTSD and addiction treatment outcomes were poorer in dually diagnosed patients than in those with just one diagnosis.

"It has really been a mini-revolution to turn that around," said Dr. Najavits, who developed an internationally adopted dual treatment module, Seeking Safety (www.seekingsafety.org).

The payoff of integrated treatment, experts agree, has offered tantalizing suggestions and some solid evidence of enhanced outcomes for symptoms of both PTSD and substance use disorders.

Once the concept was put to the test, "we realized that a great deal of 'treatment resistance' was because individuals had two, three, or four disorders, yet we were only treating one disorder," said Dr. Kathleen T. Brady, professor of psychiatry and director of the clinical neuroscience division at the Medical University of South Carolina, Charleston.

Dr. Najavits' 25-stage integrative model, which draws on four content areas:

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cognitive, behavioral, and interpersonal therapy and case management, focuses on the here and now, using practical strategies for reducing anxiety, managing relationships, and incorporating "Recovery Thinking."

Among the findings from seven empirical studies of Seeking Safety: improvements in substance use, social adjustment, general psychiatric symptoms, suicidal thoughts and planning, depression, problem solving skills, and quality of life.

In another twist on treatment delivery possibilities, Dr. McGovern recently published preliminary results of a randomized study exploring PTSD within the context of an existing addiction treatment model in 53 patients, comparing the addition of cognitive-behavioral therapy (CBT) to individual addiction counseling (Addict. Behav. 2009;34:892-97).

The now-completed study found that while both approaches led to an improvement in substance abuse disorders, the CBT component was significantly more efficacious in reducing PTSD symptoms. Furthermore, patients randomized to receive CBT "stayed in treatment at much greater rates," he said.

One development that has made dual treatment a reality has been the availability of "excellent medications" for addiction that can allow patients to focus on PTSD treatment, Dr. Kosten said.

Depot naltrexone, which persists for a month after injection, can assist in alcohol abstention, while buprenorphine reduces the need for opiates, covering two of the substances most abused by patients with co-occurring PTSD, he said.

At times, other medications directed at PTSD symptoms, such as the alpha adrenergic blockers prazosin or doxazosin, might be useful as well.

A randomized, controlled study by researchers at Yale University, New Haven, Conn., directly compared medications (disulfiram or naltrexone) to placebo in 254 patients being treated for alcohol dependence in a 12-week study conducted at three VA outpatient clinics.

Compared with study subjects without PTSD, those with the added disorder had better alcohol use outcomes and improvement of psychiatric symptoms when they received one or other of the active medications, reported Dr. Ismene Petrakis and associates (Biol. Psychiatry 2006;60:777-83).

Another study offers insight into integrated treatment for patients with opiate addictions.

The prospective observational study found comparable reductions in drug use by patients with or without PTSD when opioid substitution was employed, even though the PTSD group had a lengthier mean history of addiction (J. Stud. Alcohol 2006;67:228-35).

The PTSD subgroup used higher doses of opiate medications, but actually attended more psychosocial treatment sessions and had better treatment retention.

"I can only speculate about the difference between outcomes…but my guess is that the patients with PTSD were more sensitive to the discomfort associated with missing a dose of methadone and thus were more motivated to get to the clinic for treatment each day," the lead author of the study, Jodie A. Trafton, Ph.D., said in an interview.

If true, the increased-distress hypothesis, also postulated by other researchers, "might suggest that maintenance therapies or very slow tapers during detoxification might be particularly helpful for patients with these comorbidities," said

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Dr. Trafton, a research health science specialist who directs the VA Program Evaluation and Resource Center in Menlo Park, Calif.

Although she is not a prescriber, Dr. Najavits advocates a medical consultation for patients with co-occurring PTSD and substance abuse, to determine whether these or other medications might be helpful during the intensive Seeking Safety program.

Because it is a difficult group to treat, strategies should aim at "giving the client as much care and support as possible," including medication, 12-step group meetings, domestic violence counseling, parenting skills training, and HIV testing and counseling—essentially any adjunctive intervention that is relevant and scientifically sound.

"The more the better," she said.

One challenge shared by many of the integrated therapy models is reaching potential patients who could benefit, said Dr. McGovern.

Denial is common with both diagnoses, and even patients who are ready to tackle one issue might be reluctant to acknowledge or address the other.

PTSD, for example, might present as a sleep problem or chronic pain, either of which could prompt the writing of prescriptions with the potential of exacerbating co-occurring substance abuse.

When Dr. McGovern and associates offered free evaluations and treatments for dual diagnosis patients, they were stunned at the lack of response from the community.

"We thought if we built it they would come," he said. "We had clear recruitment challenges."

Reaching dually diagnosed patients early, when intervention is most likely to succeed, would be aided if primary care physicians as well as psychiatrists were better trained to recognize these hidden disorders, experts agreed.

A heightened awareness and specialized training also would increase the number of providers able to treat PTSD and substance abuse.

"The hardest thing for nonsubstance abuse providers to do is ask and monitor for substance abuse, including urine toxicology for illicit drugs and breath alcohol [tests] as needed," Dr. Kosten said.

His advice?

"Do not avoid discussing the use of abused drugs at the first meeting with the patient. They are more than happy to discuss it, although the younger patients do not view binge alcohol as a problem and need to be convinced."

If patients say they can quit anytime, Dr. Kosten challenges them, asking whether they will stop for a week and monitoring their adherence with a breath alcohol test during a Monday morning appointment. He also asks permission to talk to a significant other about the patient's drinking.

"It is easy when you do it right from the start and do not wait to address the 'delicate issue' of substance abuse in a patient with PTSD," he said. "They already know that it is a problem. Lots of friends and relatives have usually told them."

Asked to offer advice to clinicians treating patients with co-occurring PTSD and substance abuse, Dr. Brady emphasized the heterogeneity of the disorders.

"No two patients look alike," she said. "Every patient needs a careful evaluation and individualized treatment plan. The treatment provider must be flexible—ready to change treatment strategies if what they initially try doesn't work, because we [still] have a lot of uncertainties in treatment."

Dr. Kosten disclosed that he has served on the speakers bureau for Reckitt Benkizer, maker of buprenorphine, and as a consultant to Alkermes Pharmaceuticals, which manufactures Vivitrol (naltrexone). Dr. Brady has received research support from GlaxoSmithKline and served as a consultant for Ovation Pharmaceuticals, now Lundbeck Inc. The other experts interviewed reported no relevant financial conflicts of interest. ■